DAM Health Rodney Street

Inspection report

57 Rodney Street
Liverpool
L1 9ER
Tel:

Date of inspection visit: 26 September 2022
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Overall summary

This service is rated as Requires improvement overall.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at DAM Health Rodney Street in response to concerns raised with us. This was the first inspection since the service was registered with Care Quality Commission and was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. The service was registered with CQC on 8 March 2022.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to particular types of regulated activities and services and these are set out in Schedule 1 and Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. DAM Health Rodney Street is registered with CQC to provide treatment of disease, disorder or injury, services in slimming clinics and diagnostic and screening procedures. At the time of the inspection treatments being provided that required CQC registration included weight management treatments and travel vaccinations. They also offered vitamin therapies but had not treated any patients at the time of the inspection. The service was registered as a Yellow Fever vaccination centre but they had not offered this service to patients at the time of our inspection. DAM Health Rodney Street provides a range of other services, for example COVID -19 testing, skin treatments such as cryotherapy and occupational health services which are not within CQC scope of registration. Therefore, we did not inspect or report on these services.

Christine Cottrell is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our key findings were:

- Safeguarding systems, processes and practices were developed, implemented and communicated to staff, but these required improvement.
- The provider assessed needs and delivered care in line with relevant and current evidence-based guidance and standards.
- Staff had the skills, knowledge and experience to carry out their roles.
- Patients were treated with respect and staff were kind, caring and involved them in decisions about their care.
- Patients were able to access care and treatment from the clinic within an appropriate timescale for their needs.
- There was a complaints procedure in place and information on how to complain was readily available within the clinic but the provider's website did not contain information on how to complain.

Overall summary

- The service had systems in place to collect and analyse feedback from patients.
- The service demonstrated they were committed to improving the culture at the service and focusing on the needs of patients so they could drive improvement.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

You can see full details of the regulations not being met at the end of this report.

The areas where the provider **should** make improvements are:

- The provider should only supply unlicensed medicines against valid special clinical needs of an individual patient where there is not a suitbable licensed medicine available.
- The provider should take account of good practice guidance in the development of Patient Group Directions.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

Our inspection team was led by a CQC lead inspector**.** The team included a member of the CQC medicines team.

Background to DAM Health Rodney Street

DAM Health Rodney Street provides independent nurse led weight management and travel vaccinations for adults. The service had a total of five patients being treated for weight management and one patient who had received travel vaccines. The service also offered vitamin therapies but had not treated any patients for this at the time of the inspection.

The registered provider is DAM Health Limited. The service operates from a listed building in the centre of Liverpool at:

57 Rodney Street

Liverpool

L1 9ER

The service is open Monday to Friday 8am to 6pm for services within CQC scope of registration. It opens between 8am to 6pm on a Saturday and Sunday for COVID -19 testing services which are not within the CQC scope of registration.

Appointments are available on a pre-bookable only basis.

The staff team comprised of a chief operating officer, a clinical director, a registered manager and a clinic manager. They were supported by a team of nurses and administration staff.

How we inspected this service

Before the inspection visit we reviewed a range of information we hold about the service and information sent by the provider.

During the inspection we spoke with the chief operating officer, clinical director, registered manager, two nurses and a member of the administration team. We reviewed key documents supporting the delivery of the services, reviewed treatment records and made observations about the areas the service was delivered from.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Requires Improvement

Are services safe?

We rated safe as Requires improvement because:

The service required improvements to make sure care was provided in a way that kept patients safe and protected them from avoidable harm. Specifically:

- A disclosure and barring check (DBS) was not undertaken for a member of staff employed at the service. In the absence of a DBS check a risk assessment had not been completed.
- Some risks associated with the premises had not been identified.
- Emergency procedures referred to the use of oxygen which was not available on the premises.
- Patient follow up consultations were not always fully documented in the patient record and details of consultations were not always shared with the patients GP.

Safety systems and processes

Safeguarding systems and processes were developed and implemented in a way that kept people safe but these were not always effective.

- The provider had appropriate safety policies in place, which were regularly reviewed and communicated to staff. They outlined clearly who to go to for further guidance. Staff received safety information from the service as part of their induction and refresher training.
- There were appropriate safeguarding policies in place and staff knew how to recognise and act on suspected abuse and neglect. We were told that any concerns were reported to the provider's safeguarding lead.
- Staff received up to date safeguarding training appropritate to their role.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- Disclosure and Barring Service (DBS) checks were not always undertaken where required (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We saw that one member of staff did not have a DBS check in place and were told that they were expected to be supervised by another member of staff in the absence of a check, but there was no risk assessment completed to record this decision.
- The provider had carried out appropriate premises risk assessments including those for Legionella. However we found some shortfalls with the safety of the premises which the risk assessments had not idenitifed; a broken lock in a toilet accessible to patients, staff and visitors and some loose carpet on the stairs. The Legionella risk assessment expired in August 2022 and the provider had not made arrangements for a new assessment to be carried out at the time of our inspection.
- The provider conducted regular fire drills and we saw appropriate fire risk assessments that supported the management of fire safety.
- There were systems for safely managing healthcare waste. Sharps boxes were supplied to patients for the disposal of pen needles.
- The provider carried out other environmental risk assessments such as the control of substances hazardous to health (COSHH). We saw that substances which were hazardous to health were stored appropriately.
- There was a system to manage infection prevention and control. Staff at the service cleaned high touch points and clinical areas between each consultation or treatment. The general cleaning was provided by an external company and the premises appeared clean. A review of the records found that it was not clear which areas had been cleaned. The provider had recently devised a new cleaning schedule but it had not been implemented at the time of our inspection.

Requires Improvement

Are services safe?

- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.

Risks to patients

There were some systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and skill mix of staff needed.
- There was an effective induction system for staff which was tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place for clinical staff working at the service.
- There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly. However, we found that the provider's anaphylaxis algorithm included the use of oxygen which was not stored on site and there was no risk assessment in place to inform this decision.

Information to deliver safe care and treatment

Staff did not always have the information they needed to deliver safe care and treatment to patients.

- Individual care records were not always written and managed in a way that kept patients safe. Some consultation records lacked detail and records of follow-up telephone calls were not clearly made, signed and dated. Staff told us they planned to develop a telephone template to facilitate clear, contemporaneous record keeping.
- The service shared information with staff and other agencies to enable them to deliver safe care and treatment. However, the provider did not have a clear system, described in policy to ensure that the GP letters were sent out. Patient documentation advised that the clinic would contact patient's usual GP but consent was not recorded.

Safe and appropriate use of medicines

The service had some reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including vaccines, emergency medicines and equipment minimised risks. The service kept prescription stationery securely.
- The service had only recently started weight loss and travel vaccination services. Medicine audits had not yet been completed to ensure prescribing was in line with best practice guidelines for safe prescribing.
- The service does not prescribe controlled drugs.
- Staff prescribed, administerd and gave advice on medicines to patients in line with legal requirements and current national guidance. Nurses told us that they referred to NaTHNaC (National Travel Health Network and Centre) for up-to-date travel advice. The clinic had also registered as a Yellow Fever Centre but had not yet started to deliver this service.
- The clinic also prescribed medicines for weight loss 'off label'. Treating patients off label can have a higher risk than treating patients with licensed medicines for their labelled indication. This is because the off label use may have less safety, quality and efficacy evidence.
- There were effective protocols for verifying the identity of patients.

Track record on safety and incidents

Requires Improvement

Are services safe?

The service had a good safety record, but the documentation relating to safety issues required improvement.

- There were some shortfalls in the risk assessments in relation to safety issues.
- The service did not always monitor and review activity which helped it to understand risks. For example, the governance systems did not identify that there was an overdue risk assessment for Legionella or missing risk assessments for staff working at the service who did not have a DBS check in place. This meant that the service did not always have a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service had not had any reported significant events since they registered with CQC in March 2022. We saw evidence of the process the provider would follow if there were to be an event which included giving affected people a verbal and written apology and sharing learning following an event.
- The provider was aware of and had systems to comply with the requirements of the Duty of Candour. The service had systems in place for knowing about notifiable safety incidents
- The service acted on and learned from external safety events as well as patient and medicine safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.

Good

Are services effective?

We rated effective as Good because:

People received effective care and treatment that met their needs.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service)

- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions. We saw two examples when treatment for weight loss could not be provided and the patients were signposted to other services.
- The service planned to provide access to a dietician and psychologist to support patients receiving treatment for weight loss, but these services were not available at the time of the inspection.
- The service was small at the time of inspection and the nurse checked records to see if patients had missed appointments but there was no procedure in place for managing repeat patients.

Monitoring care and treatment

The service was not actively involved in quality improvement activity.

- The provider had not carried out any clinical audits at the time of our inspection. We saw evidence of newly developed audit tools for medicines management and infection prevention and control but these had not been implemented at the time of our inspection.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC) and Nursing and Midwifery Council and were up to date with revalidation.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- Staff whose role included immunisation had received specific training and could demonstrate how they stayed up to date.

Coordinating patient care and information sharing

Staff worked together to deliver effective care and treatment. Further action was required to improve information sharing with other organisations.

Good

Are services effective?

- Before providing treatment nurses at the service ensured they had adequate knowledge of the patient's health and their medicines history. We saw examples of patients being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment.
- Patients were not asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service.
- The provider had identified weight loss medicines that were not suitable for prescribing if the patient did not give their consent to share information with their GP, or they were not registered with a GP. We saw copies of letters sent to patients GP's but records of posting were not maintained.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- The service did not monitor the process for seeking consent.
- Patients were given written information about their medicines and the possible side effects.

Consent to care and treatment

The service did not record consent to care and treatment in line with legislation and guidance.

- Staff understood the requirements of legislation and guidance when considering consent and decision making. Nurses had received Mental Capacity Act training.

Good

Are services caring?

We rated caring as Good because:

Patients were treated with respect and staff were kind, caring and involved them in decisions about their care.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received.
- Feedback from patients was positive about the way staff treated people.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped some patients to be involved in decisions about care and treatment.

- Interpretation services were available for patients who did not have English as a first language, but there was no information displayed to inform patients of this service.
- Information leaflets were not available in easy read formats, to help patients be involved in decisions about their care. We were told that there had been no patients treated at the service who required this.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

Patients received responsive and timely access to treatment. The service took complaints and concerns seriously and had a robust process in place to investigate and act on complaints received.

Responding to and meeting people's needs

The service organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of their patients and improved services in response to those needs. For example, the service had made improvements to their booking system following feedback from patients.
- The facilities and premises were appropriate for the services delivered.
- The provider had made the building accessible to people who used wheelchairs by installing a ramp and other equipment to improve accessibility.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients had timely access to initial assessment and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients reported that the appointment system was easy to use.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and had a process in place to respond to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available within the clinic, but there was no information on the provider's website to inform people how to complain.
- The service had a complaints policy and procedure in place.
- The provider had not received any complaints relating to the part of the service we were inspecting. We saw evidence of their robust process for investigating and acting on complaints. The provider's process included acknowledging complaints, carrying out investigations and root cause analysis and identifying actions to ensure they are not repeated. The process included sharing the learning from complaints.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

The systems and processes for managing governance were not effective and there was a limited focus on continuous improvement.

Leadership capacity and capability;

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- The provider told us of their plans to develop the service at a sustainable rate. We were told that communication from the executive leadership team, who were based at the provider's head office, was not always clear about changes to the service. The provider had recently employed a Chief Operating Officer and Director of Clinical Services to support the Registered Manager in the day to day running of the service. We were told that communication from the new management structure was improving and saw that the registered manager had arranged mental health resilience training to support staff through change.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The service had a strategy and supporting business plans to achieve priorities.
- The service did not develop its vision, values and strategy jointly with staff. Some staff were not aware of the vision, values and strategy and their role in achieving them.
- The service monitored progress against delivery of the strategy. We were told that some services such as yellow fever vaccinations had not been offered to patients at the time of our inspection because the provider wanted to focus on delivering current services to a high standard before offering new services.

Culture

The service had a culture of high-quality sustainable care.

- Some staff felt respected, supported and valued by the management team. We were told that relationships between managers and staff had improved in recent months with improved communication. Staff we spoke with were proud to work for the service.
- We received some feedback that staff roles had changed in the absence of effective communication about changing responsibilities.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Staff told us they could raise concerns and were encouraged to do so with the newly appointed management team. We were told that staff would not feel confident to raise concerns with managers at executive level.

Requires Improvement

Are services well-led?

- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals. Staff were supported to meet the requirements of professional revalidation where necessary. Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of staff.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff we spoke with felt they were treated equally.
- Relationships between managers and staff were in the process of developing at the time of the inspection. We were told that the management team were actively seeking ways to improve relationships following a period of change within the service and saw evidence of the provider sharing examples of good practice and team work.

Governance arrangements

Responsibilities, roles and systems of accountability to support good governance and management required improvement.

- Leaders had not established proper policies, procedures and processes to ensure safety and assure themselves that they were operating as intended. For example, medicines policies were not always wholly reflective of the practice at the clinic. There was a vaccination clinic planned but the PGD (patient group directive) had not yet been developed and staff had not been authorised to use it.
- Staff were clear on their roles and accountabilities.
- The newly implemented management team had been in post eight weeks at the time of our inspection and they had defined new responsibilities, roles and accountabilities to improve governance systems and processes. These were not fully embedded at the time of our inspection.
- The information used to monitor performance and the delivery of quality care was accurate and useful.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Managing risks, issues and performance

There were processes in place for managing risks, issues and performance, but these required further work to make sure they were effective.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. The provider told us that they did not intend to offer further services until they had made sure that current services were running effectively and safely.
- The service had some processes to manage current and future performance. Performance of clinical staff was not demonstrated through audit of their consultations and prescribing decisions. We were shown copies of audits that the provider intended to carry out following the inspection.
- Leaders had oversight of safety alerts, incidents, and complaints.
- The provider had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The service acted on appropriate and accurate information.

Requires Improvement

Are services well-led?

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Managers told us of plans to strengthen the Clinical Governance meetings to provide oversight for policy and PGD development and review and response to alerts and incidents.

Engagement with patients, the public, staff and external partners

The service involved patients, the public and external partners to support high-quality sustainable services, but did not always involve staff.

- The service encouraged and heard views and concerns from the public, patients and external partners and acted on them to shape services and culture. We were told the provider planned to develop the patient feedback systems by introducing digital feedback outlets such as text message surveys.
- Staff could describe to us the systems in place to give feedback. For example, staff were able to feedback about the service through regular meetings and support sessions with their manager. Some staff told us that they felt there was an opportunity to feedback, but they did not always see improvements being made as a result.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was some evidence of systems and processes for learning, continuous improvement and innovation.

- Leaders told us they placed a strong emphasis on continuous learning and improvement. The service was small at the time of our inspection and the provider had not carried out any investigations into complaints or significant events, but we saw evidence that learning about communication within the service was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Services in slimming clinics Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There were limited systems or processes in place that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • The provider could not be assured they were sighted on the identification of risk for the service. For example, risk assessments had not been completed for legionella, health and safety assessments had not identified the shortfalls with the safety of the premises and risk assessments had not been completed in the absence of a DBS. • There were gaps in the providers systems and processes. For example, there was no procedure in place for managing repeat patients, the medicine policy was not wholly reflective of the practice service, consent to treatment was not clearly recorded and care records lacked detail. This was in breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014